Medical Mileage

Please list the miles round trip from your home and back. Leave the total blank. Keep one copy for your records.

DATE	NAME OF DOCTOR HOSPITAL, DRUG	R, PHYSICAL THERAPIST STORE, ETC.	MILES ROUND TRIP
		Т	OTAL
Please print your name:		Clai	im #
Address:		Telephone #	
Employer:		Today's Date	

Please send one copy to your employer or the insurance carrier. Do not send this worksheet to the Commission.